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ABSTRACT

The Health Care Reform Tracking Project is a 5-year national project to track and analyze state health care reform initiatives as they affect children and adolescents with emotional/behavioral disorders and their families. The study's first phase was a baseline survey of all 50 states to describe current state reforms as of 1995. Among findings of this survey were that 86 percent of states were involved in some type of health care reform activity. Nearly all health care reforms were focusing on Medicaid, and most involve medical waivers. The study's second phase involves an in-depth impact analysis of reforms over time in 13 states: Hawaii, Iowa, Massachusetts, North Carolina, Oregon, Pennsylvania, Rhode Island, Tennessee, Utah, Washington, Wisconsin, Arizona, and California. Preliminary results of the impact analysis include: three states indicate that health care reforms have improved access to mental health services for children, although two states report access has become more difficult. Six states report new types of providers and programs included in service networks. States also identified areas to avoid in health care reform (such as splitting acute and long-term care responsibilities between the managed care entity and the public sector) and areas to include (such as providing a single system for children with serious and mild disorders). (DB)

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Authors

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Introduction

The Health Care Reform Tracking Project is a five-year study designed to track and analyze state health care reform initiatives as they affect children and adolescents with emotional/behavioral disorders and their families. This is the only national study tracking state health care reforms as they affect this population. It is being conducted jointly by the Research and Training Center for Children's Mental Health at the University of South Florida, the Human Service Collaborative of Washington, D.C. and the National Technical Assistance Center for Children's Mental Health at Georgetown University.

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Method

The first activity of this project, completed in May 1995, was a baseline survey of all fifty states to identify and describe current state reforms. The survey was sent to State Child Mental Health Directors and State Medicaid Directors. Responses were received from all 50 states and the District of Columbia. The baseline survey will be repeated in years 3 and 5 to see how things change over time.

The second phase of the study involves an in-depth study of reforms in a smaller sample of states, tracking over time the effects on service delivery to children with emotional disorders and on systems of care for this population. Structured telephone interviews and site visits will be conducted annually for this part of the project and will include data collection from a broad range of key stockholders, including parents, state administrators, local providers, and advocates. Questions explore a broad array of access, quality, cost and other issues.

The 1995 State Survey Results

The vast majority of states (86%) are involved in some type of health care reform activity. Nearly all health care reforms are focusing on Medicaid, and most (84%) involve Medicaid waivers.

Most states are in early stages of implementation or planning. Most reforms involve both physical health and mental health. However, nearly a third of the reforms are still limiting mental health coverage.

Of the reforms reported to us, most include substance abuse services as well as mental health. However, reforms focusing on mental health services are less likely to include substance abuse services; only half of the mental health-only reforms include some provisions for substance abuse services. This points out a lack of coordination between the mental health and substance abuse communities, which may be planning their reforms independently. Considering the high co-morbidity between mental health and substance abuse problems, this approach ultimately may not make much sense.

Most reforms focus on the entire Medicaid population (60%) or some portion of the Medicaid population. If states are incrementally phasing in the Medicaid population, our data show that they are most likely to start with the population which receives Aid to Families with Dependent Children (AFDC). In almost all cases, the reforms cover both adults and children (88%). Interestingly, if there is a special age-based focus, this tends to be on children rather than on adults.

In about 72% of the reforms, representatives of the state

In about 72% of the reforms, representatives of the state mental health agency were involved in the planning process. In most but not all cases, when the mental health agency was involved, staff from the children's mental health agency also were involved. However, when the reform covered both physical health and mental health, in about 40% of the reforms, state mental health agency staff were not at all involved (and, of course, neither were children's representatives).

With respect to differential coverage, children are more likely to get different treatment, which generally represents an expanded or enriched benefit package. However, the reality is that two-thirds of the reforms do not yet recognize that children may need a different service array or an enriched benefit package.

Most states are using some type of carve out arrangement for behavioral health services (72%). Some states have carved out mental health completely and are financing and administering these services separately from physical health. Others have divided the mental health benefit (i.e., they provide partial mental health coverage with the physical health benefit and then organize a separate delivery system for persons with serious disorders or leave this population out of their managed care systems). Still others are not using carve outs, implying that mental health services are integrated with the physical health service delivery systems. We found a great deal of confusion about the term "carve out;" the term was used in some cases to describe arrangements whereby certain services or population groups are actually left out of the managed care system.

The vast majority of the reforms (88%) involve the use of capitation. All of the mental health-only reforms use capitation. States are developing separate capitation rates for a number of distinct populations (e.g., for children in general, children with serious emotional disorders, and children in state custody). Most states are using costs associated with prior utilization as the basis for determining capitation rates.

In most states, only the state Medicaid and mental health agencies are contributing dollars to finance the capitation rate. In very few instances did states report that other child-serving systems are contributing funds to finance capitation rates for children with emotional disorders.

With regard to risk, more than half of the reforms are reported to be using some type of risk adjustment (61%) to protect children with serious disorders and to protect providers. States typically are protecting themselves as much as possible from financial risk.

States are using a variety of types of entities as managed care organizations; in most cases states are using multiple entities. There is extensive use of for-profit entities, but a significant portion of the reforms are using regional or local

significant portion of the reforms are using regional or local mental health authorities or community mental health centers as the managed care organization. The data suggest that when the reform is focusing on mental health only, states are more likely to use their existing mental health structure for planning and administering service delivery than if it is a broader reform. The reforms covering both physical health and mental health seem to be relying more on the for-profit managed care entities or the for-profit managed behavioral healthcare entities. Less than half of the reforms are designating "essential providers" or providers that managed care organizations are obligated to use.

States are using a wide range of managed care techniques in the reforms they reported to us, including: (a) screeners or gatekeepers, (b) case management, (c) precertification, (d) concurrent review, (e) utilization review, and (f) preferred or exclusive provider arrangements. Only about a third reported that their reforms involved organized systems of care for children.

About half of the reforms report having some special management mechanisms for children with serious emotional disorders. These include mechanisms like intensive case management, provisions for service planning by interagency teams, and access to an enriched benefit package as noted earlier.

Around outcomes, we found that reforms are focusing on a range of dimensions. Cost, access, and utilization are the areas looked at most closely. Client outcomes and program effectiveness are the dimensions considered least in the reforms. Nearly 70% of the reforms reported that they are going to look at parent satisfaction as a dimension of outcome assessment.

Impact Analysis Preliminary Results

In the second phase of the Health Care Reform Tracking Project, now underway, we are exploring in greater depth the impact of state health care reforms on children with emotional disorders and their families and on systems of care for this population. Preliminary results were obtained from structured telephone interviews with 13 states, which included: Arizona, California,

Hawaii, Iowa, Massachusetts, North Carolina, Oregon, Pennsylvania, Rhode Island, Tennessee, Utah, Washington, and Wisconsin. These states were selected because they have some measureable experience with managed care and, as a group, provide differences in approach and geographic diversity. The preliminary information that follows is described primarily to give a sense of the kinds of issues being explored in the Phase II work. In most states, it simply is too early in the managed care initiative process to determine the impact on children and families. Hence, these issues will be followed more closely in follow-up visits.

The vast majority of states report that it is too early to tell what the impact is on child outcomes, if indeed this is even being tracked. Some states, however, are beginning to identify trends in service access.

Three of the ten states indicate that their health care reforms have made it easier for children to obtain mental health services, and two of the ten states say reform has made it more difficult, largely because medical necessity criteria restricts access to mental health services for children and the number of providers is more limited. Three of the ten states also indicate that more children are using mental health and substance abuse services as a result of their managed care initiatives. This is due to expanded coverage for uninsured and poor children and/or more Medicaid children using services. The other states say that it is still either too early to tell, or that there has been no effect on utilization. Most states are unable, at this point, to answer the question as to whether access to mental health and substance abuse services for different subgroups of children (i.e., children of color, children in child welfare, children in juvenile justice, children in special education, children with serious emotional disorders) is greater or less as a result of their managed care initiatives. It is unclear as to whether this is because it is too early to tell or whether states simply are not tracking access in this manner.

A split among the states exists over whether providers are willing to participate in the reformed system. There is also a split over whether the health care reform has meant a need for more or fewer specialized children's programs and practitioners. Six states report new types of providers and programs included in service networks through their health reforms, including: (a) social workers, (b) paraprofessionals, (c) hospital diversion programs, (d) wraparound services, (e) in home services, (f) partial hospitalization, (g) respite services, and (h) school-based services. One state reported that their reform reduced the number of providers and programs.

Most states report that more types of home and community based services are covered through their health care reform than previously. Most states also report a reduction in both the use of inpatient psychiatric hospitalization for children and the lengths of stay while utilizing inpatient. Two states report that their health care reforms have led to a reduction in out-of-home placement, but most states say it is too early to tell. One-third of the states, however, report an increase in the use of residential treatment centers, as well as "dumping" of children into residential treatment in the public sector.

Three states report increased costs associated with their health care reforms, largely due to increased access to services. Two states, however, report no effect on cost, and half say it is still too early to tell. Three states report a change in expenditure patterns, with a decrease in spending

change in expenditure patterns, with a decrease in spending on inpatient and an increase for community-based services. Most states do not know the impact of their health care reforms on costs to other child-serving systems, such as child welfare. Half of the states report greater interagency collaboration as a result of their health care reforms, but two states report that their reforms have exacerbated the issue of which system should pay for which services for which children. Four states indicate that their reforms have enhanced their ability to pool funds across children's systems, but most states say it is too early to tell or report no effect. Four states also indicated an enhanced ability to use Medicaid to finance mental health services for children as a result of their health care reforms; one state reports a diminished ability.

Half the states report that the health care reform has facilitated their development of systems of care for children, and half say it is too early to tell. Most states report that their reforms have also facilitated their ability to provide flexible, individualized services for children, but that it is more difficult to coordinate these services. The vast majority of states report that the role of their public child mental health systems has changed as a result of their health care reforms, with public child mental health assuming more monitoring and training responsibilities and, in some cases, becoming strictly a long term care provider of services. Also, most states report more integration between the public and private sectors as a result of their reforms.

Four states report an expanded role for primary care providers in identifying and treating mental health problems for children as a result of their health care reform, and some states express concern over both the need for better linkages between primary care and mental health providers and the need for better training for primary care providers in mental health issues in children. Most states do not know or report limited impact on the extent of family involvement as a result of their health care reforms. Even the three states that reported support for family involvement in their reforms indicated a need to do more.

Most states find it too early to tell if quality of services has improved. Two states report better quality, and one, diminished quality, largely due to a reduced provider capacity and restrictions on length of stay that is leading to increased recidivism. Most states also say it is too early to tell or they do not know the impact of their reforms on the cultural competence of services provided to children. Three states, however, indicated enhanced cultural competence due to inclusion in the service network of culturally competent providers and training in this area. Finally, most states report it is too early to tell if their reforms facilitate or make worse the early identification of mental health problems; however, four states report it is easier to intervene earlier because managed care moves people faster through the system.

States listed the following as the most important things to avoid in health care reform with respect to children with emotional disorders and their families:

- Splitting acute and long term care responsibilities between the managed care entity and the public sector;
- cost shifting among child-serving systems and between the managed care entity and children's systems;
- exclusion of families and advocates from planning and implementation of the health care reform;
- assuming that private managed care organizations understand public sector clients;
- categorical funding of the health care reform;
- lack of outcome measures for children;
- inadequate provider network (i.e., not properly trained, not sufficient capacity, or not right types of providers in network);
- poor understanding of prior costs and utilization; and
- hurried planning and implementation.

Conversely, states recommended that the most important elements to include in state health care reforms are:

- A single system for children with serious and mild disorders, for acute and extended care needs;
- a broad, flexible array of covered services in the benefit design;
- a system of care approach for children with serious disorders;
- family involvement in planning and implementation;
- extensive interagency involvement in planning the system;
- mandate interdisciplinary treatment teams and interagency linkages in contract language;
- delineate funding responsibilities across children's agencies;
- create a citizens review board and a complaints resolution process;
- have good data systems to plan and monitor the system;
- undertake extensive public education about the new system; and
- go slow&endash;create a deliberate and open planning process.

Discussion

Not only are states proceeding quickly with their reforms, but they are moving ahead with statewide implementation for the most part, without the benefit of pilots or demonstrations. This highlights the need for careful monitoring and evaluation of these reforms as they proceed. It also increases the likelihood that states will have to make corrections to their systems over time.

The majority of the reforms still do not recognize that children may require a different service array, an expanded benefit package, or special requirements for service delivery like interagency service planning or family involvement, creating concern about the limited use of organized systems of care for children with serious emotional disorders in managed care systems.

The use of carve outs, and the type of carve out, for behavioral health services, is an area in which states' approaches are evolving and are likely to change over time. We will need to look very closely at how well states and managed care organizations are able to manage the boundaries between carved out, left out, and integrated populations. Otherwise, we will have a great deal of cost shifting and fragmentation of service delivery, especially for children.

There is a need for better data to use as the basis to determining capitation rates for children with emotional disorders. A lot more work is needed to figure out how to track outcomes for children and families in managed care. Much of the ongoing work in this area appears to be adult-focused.

The entire issue of family and youth involvement needs further exploration. Most states reported some level of family involvement in planning their reforms, but family involvement seems peripheral, for the most part.

Over the past decade, there has been increasing awareness of the differences between children's and adults' services. These and other differences must be accounted for as states develop and refine benefits, gatekeeping systems, treatment planning and review systems, quality and outcome measures, and all other facets of managed care. Given the profound implications that managed care is likely to have, we cannot underestimate the importance of involving those with children's expertise (i.e., staff and families) at the earliest stages. There is also a clear need to better integrate other children's systems, such as child welfare, education, and juvenile justice, into the planning of managed care systems.

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